CHAPTER 1

The Rationale for Personalized Assessment in Clinical Practice

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Defining "Personalized Assessment"

"Personalized assessment" is not a vague concept or a platitudinous buzzword in our approach, but is instead an explicit commitment to focus on the unique composite of a patient's psychological makeup. That focus should be followed by a precise formulation and specification of techniques to remedy those personal attributes that are assessed as problematic.

Clinicians should take cognizance of the person from the start, for the psychic parts and environmental contexts take on different meanings and call for different responses, depending on the specific person to whom they are anchored. To focus on one social structure or one psychological realm of expression, without understanding its undergirding or reference base, is to engage in potentially misguided, if not random, techniques.

Fledgling clinicians should learn further that the symptoms and disorders they diagnose represent but one or another segment of a complex of organically interwoven psychological elements. The significance of each clinical feature can best be grasped by reviewing a patient's unique psychological experiences and his or her overall psychic pattern or configurational dynamics, of which any one component is but a single part.

Assessments that conceptualize clinical disorders from a single perspective—be it psychodynamic, cognitive, behavioral, or physiological—may be useful and even necessary, but are not sufficient in themselves as a basis for therapy of the patient. The revolution we propose asserts that clinical disorders are not exclusively behavioral or

cognitive or unconscious; that is, they are not confined to a particular expressive form. The overall pattern of a person's traits and psychic expressions is systemic and multioperational. No part of the system exists in complete isolation from the others. Every part is directly or indirectly tied to every other, such that there is an emergent synergism that accounts for a disorder's clinical tenacity.

Personality is real; it is a composite of intertwined elements whose totality must be reckoned with in all clinical enterprises. The key to treating each of our patients, therefore, lies in an assessment designed to be as organismically complex as the person him- or herself; this form of assessment should generate more than the sum of its parts. Difficult as this may appear, we hope to demonstrate its ease and utility. If our wish comes true, this book will serve as a revolutionary document—a means of bringing assessment back to the natural reality of patients' lives.

It is our hope that the book will lead all of us back to reality by exploring both the uniqueness and the diversity of the patients we treat. Despite their frequent brilliance, most single-focus clinical schools (e.g., behavioral, psychoanalytic) have become inbred. Of more concern, they persist in narrowing clinicians' attention to just one or another facet of their patients' psychological makeup, thereby wandering ever farther from human reality. They cease to represent the full richness of their patients' lives, considering as significant only one of several psychic spheres: the unconscious, biochemical processes, cognitive schemas, or some other. In effect, what has been taught to most fledgling therapists is an artificial reality—one that may have been formulated in its early stages as an original perspective and insightful methodology, but has drifted increasingly from its moorings over time, no longer anchored to the complex clinical reality from which it was abstracted.

How does our approach differ from others? In essence, we give the patient's unique constellation of personality attributes center stage in the assessment task. Only after a thorough evaluation of the nature and prominence of these personal attributes do we think through which combination and sequence of treatment orientations and methodologies we should employ. It should be noted that a parallel personalized approach to physical treatment has currently achieved recognition in what is called "genomic medicine." Here medical scientists have begun to tinker with a particular patient's DNA so as to decipher and remedy existing, missing, or broken genes, thereby enabling the physician to tailor treatment in a highly personalized manner—that is, specific to the underlying or core genetic defects of that particular patient. Anomalies that are etched into a patient's unique DNA are screened and assessed to determine their source, the vulnerabilities they portend, and the probability of the patient's succumbing to specific manifest diseases.

As detailed later in this book (notably by Grossman, Tringone, & Millon in Chapter 24), we have formulated eight personality components or domains constituting what we might term a "psychic DNA," a framework that conceptually parallels the four chemicals composing biological DNA. Deficiencies, excesses, defects, or dysfunctions in these psychic domains (e.g., mood/temperament, intrapsychic mechanisms) effectively result in a spectrum of 15 manifestly different variants of personality styles and pathology (e.g., avoidant style, borderline disorder), in the same manner as the vulnerabilities in biological DNA result in a variety of different genomically based diseases. The unique constellation of vulnerabilities as expressed in and traceable to one or several of these eight potentially problematic psychic domains is what becomes the object and focus of personalized psychotherapy.

In this book, we attempt to show that all the clinical syndromes constituting Axis I of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) can be understood more clearly and treated more effectively when conceived as outgrowths of patients' overall personality styles. To say that depression is experienced and expressed differently from one patient to the next is a truism; so general a statement, however, will not suffice for a book such as this. Our task requires much more.

The book provides extensive information and illustrations on how patients with different personality vulnerabilities react to and cope with life's stressors. This body of knowledge should guide therapists to undertake more precise and effective treatment plans. For example, a dependent person will often respond to an impending divorce with feelings of helplessness and hopelessness, whereas a narcissistic individual faced with similar circumstances may respond in a disdainful and cavalier way. Even when a dependent and a narcissistic person exhibit depressive symptoms in common, the precipitant of these symptoms will probably have been quite different; furthermore, treatment—its goals and methods—should likewise differ. In effect, similar symptoms do not call for the same treatment if the patterns of patient vulnerabilities and coping styles differ. In the case of dependent individuals, the emotional turmoil may arise from their feelings of lower self-esteem and their inability to function autonomously; in narcissistic persons, depression may be the outcropping of failed cognitive denials, as well as a consequent collapse of their habitual interpersonal arrogance.

Whether we work with a clinical syndrome's "part functions" as expressed in behavior (social isolation), cognitions (delusional beliefs), affect (depression), or a biological defect (appetite loss), or we address contextual systems that focus on the larger environment, the family, the group, or the socioeconomic and political conditions of life, the crossover point—the place where the varieties of clinical expression are linked to the individual's social context—is the person. The person is the intersection of all functions and systems. Persons, however, are more than just crossover points. They are the only organically integrated systems in the psychological domain, inherently created from birth as natural entities. Moreover, it is the person who lies at the heart of the assessment process: He or she is the substantive being who gives meaning and coherence to symptoms and traits—be they behaviors, affects, or mechanisms—as well as that being, that singular entity, who gives life and expression to family interactions and social processes.

Looking at a patient's totality can present a bewildering if not chaotic array of diagnostic possibilities, potentially driving even the most motivated young clinician to back off into a more manageable and simpler worldview, be it cognitive or pharmacological. But as we contend here, complexity need not be experienced as overwhelming; nor does it mean chaos, if we can bring logic and order to the assessment process. We try to provide such logic and order by illustrating that the systematic integration of an Axis I syndrome into its foundation in an Axis II disorder is not only feasible, but conducive to both briefer and more effective therapy.

Are not all assessments "personalized"? Do not all clinicians concern themselves with the person who is the patient they are treating? What justifies our appropriating the name "personalized" for the approach we espouse? Are we not usurping a universal, laying claim to a label that is commonplace, routinely shared, and employed by most (if not all) therapists? We think not. In fact, we believe that most clinicians only incidentally or secondarily attend to the specific personal qualities of their

patients. The majority come to their treatment task with a distinct if implicit bias, a preferred theory or technique they favor—one usually encouraged, sanctioned, and promoted in their early training (be it cognitive, group, family, eclectic, pharmacological, or what have you).

Finally, in personalized assessment we seek to employ customized instruments, such as the Grossman Facet Scales of the Millon Clinical Multiaxial Inventory–III (MCMI-III), to identify the patient's vulnerable psychic domains (e.g., cognitive style, interpersonal conduct). These assessment data furnish a foundation and a guide for implementing the distinctive individualized goals we seek to achieve in personalized psychotherapy (Millon & Grossman, 2007a, 2007b, 2007c; see also Grossman, Chapter 6, this volume).

Our Integrative Model: Natural versus Artificial Theoretical Synthesis

The simplest way to practice clinical psychology is to approach all patients as possessing essentially the same disorder, and then to utilize one standard modality of therapy for their treatment. Many therapists still employ such simplistic models. Yet everything we have learned in the past two or three decades tells us that this approach is only minimally effective and deprives patients of other, more sensitive and effective approaches to treatment. In the past two decades, we have come to recognize that patients differ substantially in their presentations of clinical syndromes and personality disorders. It is clear that not all treatment modalities are equally effective for all patients. The task set before us is to maximize our effectiveness and to outline an integrative model for selective therapeutics. When the selection is based on each patient's personal trait configuration, this integration becomes what we have termed "personalized assessment and psychotherapy."

It is our view that psychopathology itself has structural implications that should determine the form of any assessment one would propose to remedy its constituents. In this book, we present several such implications and propose a new integrative model for action. This model—which, as noted above, is guided by the psychic makeup of a patient's personality, rather than by a preferred theory, modality, or technique—gives promise, we believe, of a new level of efficacy. It is not a ploy to be adopted or dismissed as congruent or incongruent with established preferences or modality styles. Despite its name, we believe that what we have termed a "personalized" approach will be effective not only with Axis II personality disorders, but also with Axis I clinical syndromes.

It is our belief that integrated assessment should be a synthesized system that mirrors the problematic configuration of traits (personality) and symptoms (clinical syndromes) *of the specific patient at hand*. Many in the past have sought to coalesce differing theoretical orientations and treatment modalities. By contrast, those of us adhering to the personalized persuasion bypass the synthesis of theories. Rather, primary attention should be given to the natural synthesis or inherent integration that may be found within patients themselves.

As Arkowitz (1997) has noted, efforts to create a theoretical synthesis are usually not fully integrative, in that most theorists do not draw on component

approaches equally. Most are oriented to one particular theory or modality, and then seek to assimilate other strategies and notions to that core approach. Moreover, assimilated theories and techniques are invariably changed by the core model into which they have been imported. In other words, the assimilated orientation or methodology is frequently transformed from its original intent.

By seeking to impose a theoretical synthesis, clinicians may lose the context and thematic logic that each of the standard theoretical approaches (e.g., behavioral, psychoanalytic) has built up over its history. In essence, intrinsically coherent theories are usually disassembled in the effort to recombine their diverse bits and pieces. Such integrative models may be pluralistic, but they reflect separate modalities with varying conceptual networks and their unconnected studies and findings. Therefore, these models do not reflect that which is inherent in nature; instead, they represent schemas for blending what is, in fact, essentially discrete.

Intrinsic unity cannot be invented, but can be discovered in nature by focusing on the intrinsic unity of the person—that is, the full scope of a patient's psychic being. Integration based on the natural order and unity of the person avoids the rather arbitrary efforts at synthesizing disparate and sometimes disjunctive theoretical schemas. Unlike eclecticism, true integration insists on the primacy of an overarching gestalt, provides an interactive framework, and creates an organic order among otherwise discrete units or elements. Whereas theoretical syntheses attempt to provide intellectual bridges across several theories or modalities, personalized integrationists assert that a natural synthesis already exists within the patient. As we better understand the configuration of traits that characterize each patient's psyche, we can better devise a treatment plan that will mirror these traits and, we believe, will provide an optimal therapeutic course and outcome.

Integration is an important concept in considering not only the assessment of the individual case, but also the place of assessment in clinical science. For the treatment of a particular patient to be integrated, the elements of a clinical science—theory, taxonomy, assessment, and therapy—should be integrated as well (Millon & Davis, 1996b). One of the arguments advanced earlier against empirically based eclecticism is that it further insulates assessments from a broad-based clinical science. In contrast to eclecticism, where techniques are justified empirically, personalized assessment should take its shape and character from an integrative theory of human nature. Such a grand theory should be inviting because it attempts to explain all of the natural variations of human behavior, normal or otherwise; moreover, personalized assessment will grow naturally out of such a personalized theory. Theory of this nature will not be disengaged from technique; rather, it will inform and guide it.

Murray (1983) has suggested that the field must develop a new, higher-order theory to help us better understand the interconnections among cognitive, affective, self, and interpersonal psychic systems. This belief is shared by personalized assessment theorists such as ourselves, who claim that interlinked configurations of pathology deduced from such a theory can serve to guide assessments.

The cohesion (or lack thereof) of intrinsically interwoven psychic structures and functions is what distinguishes most complex disorders of psychopathology; likewise, the orchestration of diverse yet synthesized modalities of intervention is what differentiates synergistic from other variants of clinical practice. These two parallel constructs, emerging from different traditions and conceived in different venues, reflect

shared philosophical perspectives—one oriented toward the understanding of mental disorders, the other toward effecting their remediation.

Some Philosophical Issues

Before turning to these themes, we would like to comment briefly on some philosophical issues. They bear on our rationale for developing a wide-ranging theory of nature to serve as a basis for both assessment and treatment techniques—that is, universal principles that transcend the merely empirical (e.g., electroconvulsive therapy for patients with depression). It is our conviction that an integrated theoretical foundation of our personological science is essential if we are to succeed in constructing a personalized approach to all aspects of clinical practice.

We believe that several elements characterize all mature clinical sciences: (1) They embody conceptual theories based on universal principles of nature from which their propositional deductions can be derived; (2) these theories provide the basis for coherent taxonomies that specify and characterize the central features of their subject domain (in our case, that of personality and psychopathology, the substantive realm within which scientific psychotherapeutic techniques are applied); (3) these taxonomies are associated with a variety of empirically oriented assessment instruments that can identify and quantify the concepts that constitute their theories (in psychopathology, methods that uncover developmental history and furnish cross-sectional assessments); and (4) in addition to natural theory, clinical taxonomy, and empirically anchored assessment tools, mature clinical sciences possess change-oriented intervention techniques that are therapeutically optimal in modifying the pathological elements of their domain.

Most current clinical schools of thought share a common failure to coordinate these four components. What differentiates them has less to do with their scientific grounding than with the fact that they attend to different levels of data in the natural world (e.g., cognitive processes, neurochemical dysfunctions). It is to the credit of those of an eclectic persuasion that they have recognized, albeit in a fuzzy way, the arbitrary if not illogical character of single-focus positions, as well as the need to bridge schisms among these approaches that have evolved less from philosophical considerations or pragmatic goals than from accidents of history (Millon, 2004). There are numerous other knotty issues with which personalized assessment and therapy must contend (e.g., differing worldviews concerning the essential nature of psychological experience). There is no problem, as we see it, in encouraging active dialectics among these contenders.

However, two important barriers stand in the way of personalized assessment as a philosophy. The first is the DSM. The idea of diagnostic prototypes was a genuine innovation when the DSM-III was published in 1980. The development of diagnostic criteria work groups was intended to provide broad representation of various viewpoints, while preventing any single perspective from foreclosing on the others. Over 25 years later, however, the DSM has not yet officially endorsed an underlying set of principles that would interrelate and differentiate the categories in terms of their deeper principles. Instead, progress proceeds mainly through committee consensus, cloaked by the illusion of empirical research.

The second barrier is the human habit system. The admonition that different clinical approaches should be pursued with different patients and different problems has become almost self-evident. But, given no logical basis for designing effective therapeutic sequences and composites, even the most self-consciously antidogmatic clinician must implicitly lean toward one orientation or another.

It should also be noted that the methodology through which most assessment instruments are created is opposed in spirit to the goal that directs their use. In tapping dimensions of individual differences, we abstract from persons only those dimensions we take as being common to all. Yet, in using such instruments, we seek to build up again as a reconstructive process the very individuality we had previously disassembled, so that the circle completes itself as a kind of synthesis: from rich idiographic individuality, to nomothetic commonalities, and finally to nomothetic individuality. Apparently, we must segment and give up the person first, and then recombine them, if we are ultimately to understand him or her.

Personalized assessment is concerned with the last two links of this process. The fractionated person—the person who has been dispersed across scales and instruments—must be put back together again as the organic whole he or she once was. How is such a venture to be achieved? First, assessment is an eminently theoretical process; indeed, it is an evolutionary process that requires a weighing of this and a disqualifying of that across the idiosyncrasies and commonalities of methods and data sources through multiple iterations of hypothesis generation and testing. The eventual goal, of course, is *the* theory of the patient, wherein every loose end has been tied up in a theory that follows the logic of the patient's own psyche—a theory so compelling that one gets the feeling that things could not be otherwise than they have been supposed to be. Only such an eminently integrative theory allows the referral question to be addressed with confident words and concrete suggestions.

Although we are undoubtedly biased in our appraisal, we believe that no other inventory offers as potentially complete an integrative assessment of problematic personality styles and classical psychiatric disorders as does the MCMI-III. Moreover, perhaps no other instrument is as coordinated with the official DSM taxonomy of personality disorders as is the MCMI-III, or as conceptually consonant with the multiaxial logic that underlies the DSM. In fact, the MCMI-III is but one (essential) link in what has emerged as an integrative schema for conceptualizing both personality and abnormal behavior (Millon, 1969, 1981, 1990).

As noted above, personalized consonance is an ideal worthy not only in the individual assessment case, but within a science as well. Rather than being developed independently as free-standing and uncoordinated structures, a mature clinical science of psychopathology should include the four components we have listed earlier. To restate these a bit differently, such a science should embody explicit (1) *theories*—that is, explanatory and heuristic conceptual schemas that are consistent with established knowledge; (2) a *nosology*—that is, a taxonomic classification of disorders that has been logically derived from the theory, arranged to provide a cohesive organization within which major categories can be grouped and differentiated; (3) *instrumentation*—that is, tools that are empirically grounded and sufficiently sensitive quantitatively to enable the theory's propositions and hypotheses to be adequately investigated and evaluated, and to permit the categories constituting its nosology to be readily identified (diagnosed) and measured (dimensionalized); and (4) *interven-*

tions—that is, strategies and techniques of therapy that are designed in accord with the theory, targeted toward areas specified by the instrumentation, and oriented to modify problematic clinical characteristics (Millon, 1990).

The goals of this book are largely derived from the framework identified in the preceding paragraph. Operating on the assumption that clinicians desire "knowledge why" as much as "knowledge that"—in other words, that clinicians want to know not only what they should do, but also why they should do it—we will try to embed the "how" of the MCMI (and its associated inventories) in the "why." Perhaps test users will then feel that they are doing something more than merely following a flowchart or a chain of stimulus–response bonds to its termination in the clinical report: They must understand the test to understand their clients. And because the test is embedded in a theoretical matrix, they must understand the theory to understand the test. This requires a justification, not merely a dispensation.

Before we begin, we must express a few reservations. In a chapter such as this, which features a particular instrument but nevertheless seeks to illuminate integrative links among the four domains of clinical science, some highly relevant issues must be greatly abbreviated or completely omitted. As a result, what otherwise might appear as a well-worn, incremental theoretical pathway contains abrupt transitions. Most of the more theoretical material presented may be found in *Toward a New Personology: An Evolutionary Model* (Millon, 1990) and *Disorders of Personality: DSM-IV and Beyond* (Millon & Davis, 1996a). Other concerns have been treated at a level of abstraction more gross than their gravity requires. Here must be included the descriptions, developmental pathways (all but omitted), and specific intervention opportunities for each of the personality disorders and their more common two-point variants. Much of this information is available in *Disorders of Personality* (Millon & Davis, 1996a). In an ideal world we should adopt ideal goals, but in a less than ideal world, we must often adopt pragmatic ones.

The Process of Personalized Assessment

The words "integrative" and "personalized" are now used so widely as to be platitudinous: Obviously, given an equivalence of purpose, that which is more integrated is better than that which is less integrated. However, integration neither springs into being fully formed, nor is unveiled or discovered in a single conceptual leap. Instead, integration is perhaps better understood as a dynamic process. Such a conception sees knowledge building as an ongoing activity in which internal inconsistencies are generated and resolved or transcended at successively superordinate levels of conceptualization: While reality is undoubtedly integrated, our ideas about reality must be more or less so. An inquiry into the nature of this process will be worthwhile, because, as we intend to show, essentially the same logic underlies profile interpretation, thus creating another link between theory and instrumentation.

Pepper (1942) formalized the integrative means of knowledge building as a worldview that he called "organicism," one of his four relatively adequate "world hypotheses" or metaphysical worldviews. Pepper described seven categories of organicism, which work in a kind of dialectical interplay between appearance and reality—one that always proceeds in the direction of increasing integration:

> These [categories] are (1) *fragments* of experience which appear with (2) *nexuses* or connections or implications, which spontaneously lead as a result of the aggravation of (3) *contradictions*, gaps, oppositions, or counteractions to resolution in (4) an *organic whole*, which is found to have been (5) *implicit* in the fragments, and to (6) *transcend* the previous contradictions by means of a coherent totality, which (7) *economizes*, saves, preserves all the original fragments of experience without any loss. (p. 283; italics in original)

We expand upon this description as follows: (1) Observations (fragments) lead one to (2) form inchoate theoretical propositions (nexuses), which, unfortunately, do not all mesh harmoniously, automatically producing (3) aggravating and ostensibly irreconcilable inconsistencies (contradictions) which are resolved through (4) a unified theory (organic whole), which, upon reflection, is (5) found to have been implicit in the observations (fragments) all along. Thus it (6) transcends the initial, naive inconsistencies among observations by reconceptualizing these observations in terms of a new, coherent theoretical model—one that (7) integrates or accounts for all the evidence (economizes) according to its new terms and relationships.

Undoubtedly, even this is a lot to digest in a few paragraphs. Extrapolating from the logic presented above, we might say that as a body of implicit theories is formalized, hiatuses are discovered, and the theories inevitably become enmeshed in inconsistencies and contradictions. Eventually, a new theory is formulated that unifies disparate observations and inconsistencies. What was believed to have been contradictory is discovered not to have been so at all, but only to have appeared contradictory, much as special cases are transcended by more general formulations.

By this account, science cannot exist merely as a descriptive venture that consists of observing, categorizing, and cross-correlating various phenomena at face value. Instead, it proceeds by establishing superordinate theoretical principles that unify the manifestations of a subject domain by explaining why these particular observations or formulations obtain rather than others. The "limit of this series" (Pepper, 1942) is truth itself—what physicists have called the theory of everything, and what philosophers (notably Hegel) have called the absolute. In this ultimate integration, "logical necessity would become identified with ultimate fact" (Pepper, 1942, p. 301). Nothing would remain unassimilated; everything would be harmonized with everything else.

More than anything else, it is the question "Why this rather than that?" that underlies the force toward integration in this worldview. By answering this question, we escape what is arbitrary and capricious, and move in the direction of necessity. In its most radical form, this argument holds that even if reliable observations of great or even perfect positive predictive power could be made through some infallible methodology, these indicators would stand simply as isolated facts unassimilated as scientific knowledge until unified through some theoretical basis. Predictive power alone does not make a science. Scientific explanations appeal to theoretical principles that operate above the level of superficialities—principles that are sufficient because they predict, and necessary because they explain.

The process of clinical assessment follows essentially the same logic. Following Pepper (1942), we might say this: The individual scales, instruments, and other data are the (1) fragments. These possess (2) nexuses, implications, or (statistically)

intercorrelations both with each other and with other clinical phenomena, leading to inchoate theories about the individual and his or her psychopathology. Inevitably, these theories do not mesh; they cannot be assimilated to each other exactly, leading to (3) contradictions, gaps, or inconsistencies in the assessment thus far. One then steps back, seeking (4) a more integrative theory or organic whole that makes sense of the gaps or inconsistencies. This integrative theory is then found to have been (5) implicit in the scales, observations, and other data (otherwise, an integrative assessment would not be possible at all), and to (6) transcend the foregoing inconsistencies, gaps, or contradictions by means of a coherent totality, which (7) makes sense of all the observations by tying up all loose ends.

In an integrative assessment, one is required to step outside the theoretical fecundity and inevitable contradictions of a morass of scales and data domains to develop a theory of the patient in which all the data somehow make sense. This superordinate theory lies literally at a higher level of formulation than do the individual measures constituting the "raw data" of the assessment. Thus the "loop" from idiographic individuality to nomothetic commonality to nomothetic individuality is brought to closure: Nomothetic individuality explicitly requires the reintegration of the individual, who currently lies fractionated among various scales and dimensions. An integrative assessment, then, does not come into being of its own accord, but is constructed, and its validity is linked to the mode of its construction.

The underlying assumption here is that things do not fit together equally well in all possible combinations. What exists in one personological domain constrains what can exist in another; otherwise, there would be no nexuses or implications across domains. An individual born with an active temperament, for example, is unlikely to possess a phlegmatic phenomenology as an adult; that is, biophysical construction constrains the quality of subjective realities that can evolve in the individual life. The same is true of all the domains of personality: They do not fit together equally well in all combinations. Functional and structural attributes for each of the personality prototypes have been delineated in several prior publications (Millon, 1986, 1990) and are explored in later chapters of this book.

Interestingly, the logic described above presents a point of contrast with that of inventories derived through factor analysis. Orthogonal factors by definition are independent: Scores on one factor do *not* constrain what can exist on any other. The extracted traits do not influence each other in any way. Thus, while factor analysis represents a parsimonious way of looking at a particular area, it implicitly holds that the structure of reality is distinctly unintegrated: There are a few essential underlying dimensions that determine a great variety of appearances, but these dimensions do not constrain each other. It is interesting, then, to speculate whether the methodology of factor-analytic test construction might be inherently inconsistent with the epistemology of test interpretation—indeed, of clinical psychology as a field. The position that fundamental dimensions exist independently runs counter to the clinician's desire to put the patient back together again.

Why should we formulate a personalized assessment approach to psychopathology? The answer may be best grasped if we think of the psychic elements of a person as analogous to the sections of an orchestra, and the trait domains of a patient as a clustering of discordant instruments that exhibit imbalances, deficiencies, or conflicts within these sections. To extend this analogy, a clinician may be

seen as the conductor, whose task is to bring forth a harmonious balance among all the sections, as well as their specifically discordant instruments—muting some here, accentuating others there, all to the end of fulfilling the conductor's knowledge of how the composition can best be made consonant. The task is not that of altering one instrument, but of assessing all in concert. What is sought in music, then, is a balanced score, one composed of harmonic counterpoints, rhythmic patterns, and melodic combinations. What is needed in clinical assessment is a likewise balanced program—a coordinated strategy of counterpoised scales and instruments designed to optimize an understanding of the different components that make up the personality as a whole.

If clinical syndromes were anchored exclusively to one particular trait domain (as phobias have been thought to be primarily behavioral in nature), single-scale assessments might be appropriate and desirable. Psychopathology, however, is not exclusively behavioral, cognitive, biological, or intrapsychic—that is, confined to a particular clinical expression. Instead, it is multioperational and systemic. No part of the personality system exists in complete isolation. Instead, every part is directly or indirectly tied to every other, such that a synergism lends the whole a tenacity that makes the full system of pathology "real"—a complex that needs to be fully reckoned with in a comprehensive assessment endeavor. Assessments should mirror the configuration of as many trait and clinical domains as the syndromes and disorders they seek to remedy. If the scope of the assessment is insufficient relative to the scope of the pathology, the clinician will have considerable difficulty fulfilling his or her meliorative and adaptive goals.

Once again, personality and psychopathology are neither exclusively behavioral, exclusively cognitive, nor exclusively interpersonal. Instead, each is a genuine integration of each of its subsidiary domains. Far from overturning established paradigms, such a broad perspective simply allows a given phenomenon to be treated from several angles, so to speak. Even open-minded clinicians with no strong allegiance to any one point of view may avail themselves of a kaleidoscope of assessment tools. By turning the kaleidoscope, by shifting paradigmatic sets, they can view the same phenomenon from any of a variety of internally consistent perspectives. But this can be only a first step toward synthesizing the interacting configuration of each patient's traits and disorders.

An open-minded clinician who makes no move toward such a synthesis is left with several different assessment tools to choose from, each with some utility for understanding a patient's pathology, but no real means of bringing these diverse instruments together in a coherent model of what exactly is the personality as a whole. The clinician's plight is understandable, but not acceptable. For example, assessment techniques considered fundamental in one perspective may not be so regarded in another. The interpersonal model of Lorna Benjamin (1996) and the neurobiological model of Robert Cloninger (1986, 1987) are both structurally strong approaches to understanding personality and psychopathology. Yet their fundamental constructs are different. Rather than adopting the assessment focus of a particular perspective, then, adherents to the theory of the person as a total system should seek some set of tools that can provide a basis for the patient's whole psyche, capitalizing on the natural organic system of the person. The alternative is an uncomfortable eclecticism of unassimilated partial views.

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